AMERICORPS HEALTH CARE ROSTER FORM

Page _____ of _____

Please complete this form and fax to SRC at (803) 865-3787 by the 15th of each month
(late or incomplete reports may require adjustments on future invoices).

PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION

PART A—PROGRAM INFORMATION

Program Number 0 0 0 ☐☐☐☐☐	Program Name	☐ No Changes
Program Administrator	Report Completion Date MM DD YY ☐☐/☐☐/☐☐	
Signature	Phone Number (☐☐☐)☐☐☐-☐☐☐☐	

PART B—INSTRUCTIONS

1. Complete an *AmeriCorps Health Care Roster Form* each month, to include new enrollments, ineligibles, changes, terminations, and Changes of address.
   a. Include in Part D, all new enrollment ***and*** any changes in previously reported data since your last report.
   b. For each insured listed in Part D, please be sure to complete all columns and enter the appropriate Code. ➡
   c. The last known home address must be included for all terminations, so that SRC can send a Continuation of Coverage Election Form.
2. *Even if there is no activity to report, you must submit a completed Roster Form each month.* For months with no activity, simply complete Part A and check "No Changes."
3. **Fax completed Roster Form to (803) 865-3787.**
4. Rosters must be received at SRC by the 15th of each month. Information reported on Rosters received after the 15th will be processed the following month.
5. Credits or adjustments that have occurred during the past two months will be applied.

ACTION CODES

N	=	New Enrollment for AmeriCorps Members
NPF	=	New Enrollment for Promise Fellows
NPT	=	New Enrollment for Part-Time Members
R	=	Reinstatement of Coverage
I	=	Ineligible Member
D	=	Drop Coverage For Insured
T	=	Terminated (give last known home address)
C	=	Name, Address, or SS# Change
W	=	Waived Coverage

PART C—PROGRAM END INFORMATION

Check here ☐ if program has ended. Enter End Date MM DD ☐☐/☐☐ Reason: ☐ Funding Ended ☐ No Full-Time Enrollment ☐ Changed Carriers

Will your program return? Yes ☐ No ☐ Date of Return MM DD ☐☐/☐☐ Projected number of enrollment

PART D—ENROLLMENT INFORMATION

Social Security Number	First Name	Last Name	Sex	DOB	Hire Date	Action Code	Action Date (MM/DD/YY)	Street Address	City, State, Zip Code